# *FASTFACTS*
# ABOUT DRUGS

ALCOHOLISM FOUNDATION
OF MANITOBA

92-07389/

# *FASTFACTS* ON DRUGS

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**May, 1992**

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## ACKNOWLEDGEMENTS:

***FASTFACTS* ON DRUGS** was made possible with the assistance of many individuals. While we are not able to acknowledge all of those who have contributed to the development of this publication, the following merit special mention: **Const. Dave Daniels**, Research and Planning Unit, Winnipeg Police Department; **Dr. Ruby Grymonpre**, Faculty of Pharmacy, University of Manitoba; **Mr. Ronald Guse**, Deputy Registrar, The Manitoba Pharmaceutical Association; Insp. **Ray Johns**, Vice Division, Winnipeg Police Department; **Ms. Diane Kennett**, Coordinator, Multiple Prescription Program, College of Physicians and Surgeons of Manitoba; **Sgt. Rod Noseworthy**, Drug Awareness Coordinator, RCMP; and **Ms. Ellen Tabisz**, Coordinator, Department of Social Work, St. Boniface Hospital.

The authors also acknowledge the contributions of the following individuals from within the Alcoholism Foundation of Manitoba: **Mr. Norm Taylor**, Supervisor, Community Prevention and Education; **Mr. Bob Davis, Mr. Barry Fogg, Mr. Zenon Lisakowski** and **Ms. Lucille Meisner**, Prevention Education Consultants. Last, but not least, the authors acknowledge the important contributions of the AFM Library: **Ms. Rita Shreiber**, Library Services Manager; and **Ms. Pat Riopka**, Library Technician.

## 1.0 INTRODUCTION

***FASTFACTS on DRUGS*** is a production of the Awareness and Information Unit of the Alcoholism Foundation of Manitoba. It is not intended to provide in-depth analysis or original research, but is designed, instead, as a quick reference for individuals interested in general statistics and trends regarding the consumption of drugs other than alcohol.

The information provided within this edition generally originates from sources outside of the AFM. The data from these sources have been summarized, with the intent that readers will initiate further review of any information which is of interest to them. We have endeavoured to authenticate the accuracy of the information contained within ***FASTFACTS*** to the greatest degree possible. This includes providing the sources of this information with the opportunity to review this document in its draft form. Responsibility for these data rests with these sources.

The AFM-specific data contained within ***FASTFACTS*** relate to the demographics and consumption patterns of clients of the Foundation. These are derived from the Foundation's own information system, the Uniform Data System (UDS).

This edition of ***FASTFACTS*** highlights drugs other than alcohol. Our primary focus is the consumption patterns, and the consequences of consumption, for youth and the elderly, along with the relationship between drug consumption and gender. There are also sections which explore issues relating to drugs and the criminal justice system, the abuse of prescription medications, and Manitoba's Multiple-Doctoring Program.

It was our original intention to focus primarily upon Manitoba-based data, especially as these related to youth and senior populations. However, after extensive exploration, it is apparent that there is a lack of regional data specifically related to these areas of inquiry. Of particular concern is the lack of province-wide information regarding youth alcohol and other drug consumption patterns and attitudes. The fact that Manitoba is one of the only provinces which has not undertaken an overall study of this nature indicates the need for future research on this topic, as a precursor to the development of youth-oriented prevention and treatment initiatives.

The AFM has an extensive library of audio-visual and printed materials. These are available to the public through a loan system. The reader is encouraged to learn more about drug use, abuse and addiction. For additional information on this publication, or on substance abuse, contact the **AFM Library/Resource Centre** at (204) 944-6233, or one of the offices listed on the back cover of this edition.

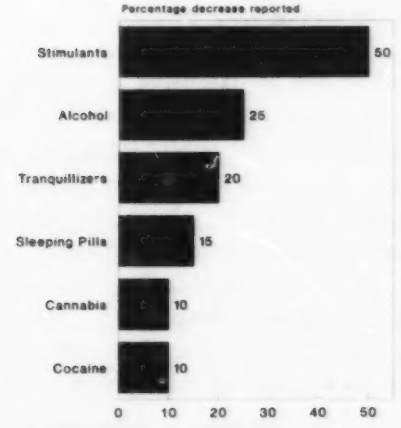
**NOTE: Throughout this edition reference is made to data with a high sampling variability and to suppressed data. These are terms used by Health and Welfare Canada to describe the effect of the coefficient of variation (cv) or standard error. Where the cv is between 16.6% and 33.3% a high variability is noted. Where the cv is greater, the data are suppressed.**

## 2.0 A BRIEF OVERVIEW OF CONSUMPTION PATTERNS FOR LICIT AND ILLICIT DRUGS

In 1985, the two of the most popular psychoactive drugs were alcohol and cannabis. As reported in the **Active Health Report**, Health and Welfare Canada, 80% of the population reported they had consumed a drink within the "last twelve months," while 6% reported they had used cannabis within the past six months.[1]

Between 1985 and 1990, some promising indications emerged regarding the reduction of the consumption of certain substances (Figure 2.0).[2] Some of the more notable changes during this period included a fifty percent reduction in the percentage of Canadians reporting the use of stimulants; a twenty percent reduction in those using tranquillizers; a fifteen percent reduction in Canadians reporting the use of sleeping pills; and a ten percent reduction in the numbers reporting the use of cocaine and cannabis. This compares with a twenty-five percent reduction in the number of Canadians reporting the use of alcohol.

Figure 2.0 Decrease In Drug Use in Canada: 1985 through 1990

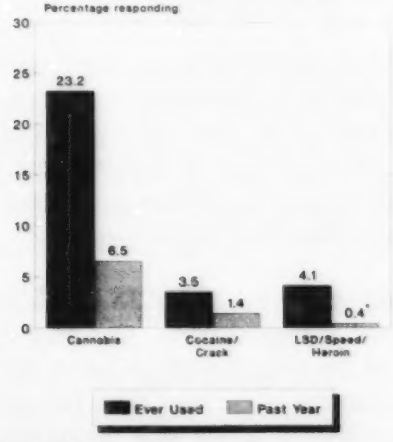



Source: Health and Welfare Canada cf. Globe and Mail, April, 1992

## 2.1 ILLICIT DRUGS IN CANADA

If only illicit, mood-altering drugs are considered, the order in which drugs are

Figure 2.1 Use of Selected Illicit Drugs in Canada, 1989

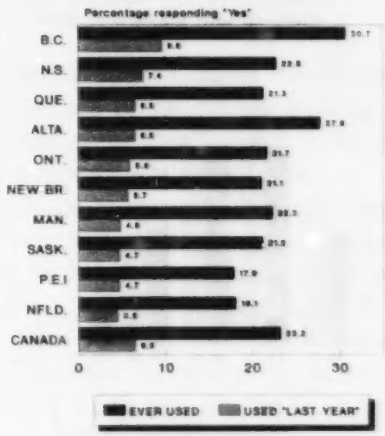



Source: NAD Survey, 1989
(*High Sampling Variability)

most likely to be used includes cannabis, cocaine, crack, LSD, speed and heroin.

However, in 1989, the **National Alcohol and Other Drugs Survey**[3] (NADS) reported that less than 10% of the adult Canadian population used these drugs, as shown in Figure 2.1. Current usage patterns are quite low, compared with those who reported that they had ever consumed these substances. For example, only 1.4% of Canadians reported the current consumption of cocaine and/or crack, while less than half of one percent of these respondents reported the current consumption of LSD, speed or heroin.

Figure 2.2 Cannabis Use by Province, 1989




Source: NAD Survey, 1989

## USE OF ILLICIT DRUGS VARIES BY PROVINCE

The reported use of illicit drugs varies among the provinces (Figure 2.2). For the most prevalent drug, cannabis, the highest rate of **current usage** occurs in British Columbia, with 9.6% of those ages fifteen and older reporting its consumption. This is followed by Nova Scotia (7.4%), and Alberta (6.5%). Quebec, Manitoba, Ontario, Newfoundland, Prince Edward Island, and Saskatchewan all reported rates below the national average of 6.5%.

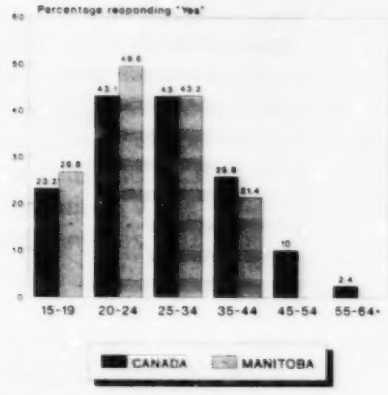
Reflecting upon those who reported **ever having used** cannabis, these figures are much larger. Nationally, 23.2% of respondents over fifteen years of age reported having used cannabis at some point in their lives.

The percentage of Canadians reporting ever having used cannabis ranges from a high of just over thirty percent of those residing in British Columbia, and 27.8% of those from Alberta, to a low of 18.1% of those in Newfoundland and 17.9% of those from Prince Edward Island, over the age of fifteen years.

## USE OF CANNABIS BY AGE

When respondents of the NADS study were asked whether they had ever consumed cannabis, the largest proportion of those responding in the affirmative were between the ages of twenty and thirty-four (Figure 2.3). Forty-three percent of these respondents indicated that they had used cannabis **at some time in their lives.**

Figure 2.3 Those Who Reported Ever Having Used Cannabis, by Age: Canada and Manitoba, 1989




Source: NAD Survey, 1989.(+High Sampling Variability; Data for populations ages 55 and over were supressed.)

These are followed by those between the ages of thirty-five to forty-four years of age (25.8%); fifteen to nineteen (23.2%); forty-five to fifty-four (10.0%); and fifty-five to sixty-four years of age (2.4).

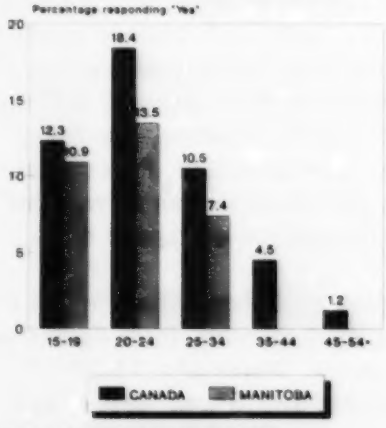
Looking at reported life-time consumption for Manitobans included in this study, the first observation which can be made is that general trends, regarding reported lifetime consumption of cannabis by age, are relatively similar to that reported on a national level.

However, two differences also emerge with regard to these data: The proportion of Manitoban respondents, ages fifteen to nineteen, who reported lifetime consumption somewhat exceeded the national statistics for this age grouping: 26.8% compared with 23.2%. This finding also applied to Manitobans between the ages twenty to twenty-four: with 49.6% of Manitobans in this age bracket reporting lifetime consumption, compared with a national average of 43.1%.

National patterns of **current cannabis consumption** in 1989 indicate that young people between the ages of 20 to 24 years are more likely than any other age group to be current users of cannabis, with 18.4% of this population reporting consumption. As age increases beyond this point, use appears to decrease.

The very low rates of current use among adults aged 35 and older (less than 5%) suggests that most adults may abandon illicit drug use on their own accord in their later years under-report its usage (Figure 2.4).

Figure 2.4 Current Users of Cannabis by Age: Canada and Manitoba 1989




Source: NAD Survey, 1989.(+High Sampling Variability; Data for populations ages 55 and over were supressed.)

For Manitoba, the NAD Survey indicates that current consumption of cannabis, by age groups, peaks at the fifteen to twenty-four year range. Just under eleven percent of respondents from ages fifteen to nineteen reported its consumption, while 13.5% of those ages twenty to twenty-four reported current consumption.

For older respondents, rates of reported consumption drops off. Only 4.7% of those between twenty-five to thirty-four reported current consumption of cannabis. Related data regarding respondents over the age of thirty-four were suppressed due to insufficient numbers.

## AGING OF HIGH-USE COHORTS

In Ontario, and perhaps in other regions of the country, usage rates for cannabis are increasing among older age groups while they are decreasing for younger age groups.[4] For example, between 1982 and 1991, the usage rate dropped from 22.7% to 14.4% in the 18 to 29 year old group, but the rate rose from 4.2% to 9.1% in the 30 to 39 year old group and from less than 1% to 4.1% in the 40 to 49 year old group.

Expectations are that the high-use drug groups of the late seventies and early eighties will continue to create a heightened "cohort bulge" as they move through the later age groups, even though the majority of this group, too, will likely cease using cannabis as they grow older.

## NATIONAL TREND DATA FOR CANNABIS CONSUMPTION

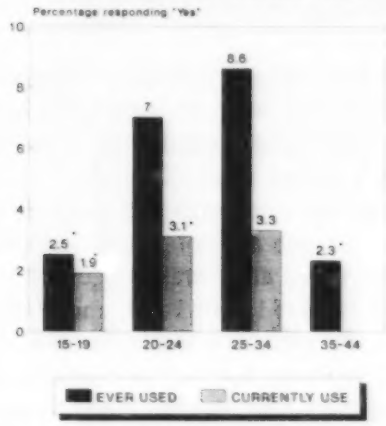
Health and Welfare Canada surveys over the last decade or so indicate a likely decline and some levelling off in the use of cannabis among adult Canadians. Although the categories and methods of various surveys are not exactly consistent, they do record an overall usage rate of 10% in 1978, 11% in 1980, and 10% in 1981.[5] By 1985, the Health Promotion Survey reported that use of cannabis had dropped to 5.6%, and the NAD Survey in 1989 reported a rate of 6.5%.

## COCAINE USE PEAKS IN OLDER AGE GROUPS

Like the pattern for cannabis use, cocaine use by adults also declines with age (Figure 2.5). However, cocaine use also peaks in an older age group. According to the 1989 NAD Study, the period of "current" highest cocaine use occurs within the 20 to 34 year old age group.

Just over three percent of the respondents to this study between ages twenty to twenty-four reported that they had consumed cocaine during the year preceding the study, while 3.3% of those between the ages of twenty-five to thirty-four did so. A relatively small proportion of respondents under the age nineteen reported current consumption of this substance, as did those over thirty-five years of age.

Figure 2.5 Current and Past Users of Cocaine by Age: Canada, 1989




Source: NAD Survey, 1989.(*High Sampling Variability; Data, ages 45+ suppressed, as were current data ages 35-44 years.)

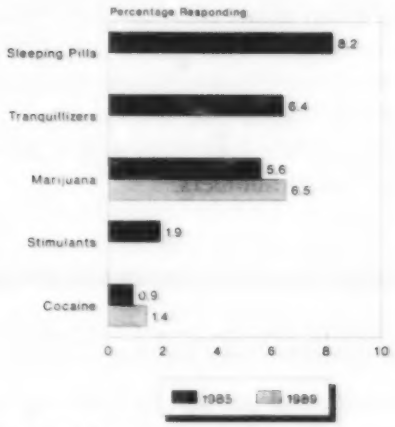
Trends regarding those who reported ever having used cocaine are similar to those noted above, with respondents in the twenty to thirty-four year range representing the largest proportion of these.

## 2.2 LICIT DRUGS

In any discussion regarding the consumption of legal psychoactive drugs, it is important to acknowledge that they do have valid medical uses.

Although national survey data in 1985 and 1989 do not distinguish between medical and non-medical use of psychoactive prescription drugs, the data for 1985 indicate the relative importance of these drugs among the drugs most likely to be abused. For instance, the **Canada Health Promotion Survey** of Health and Welfare Canada found that, in 1985, marijuana ranked third in use (after sleeping pills and tranquillizers) among a list of five drugs (Figure 2.6).[6]

Figure 2.6 Use of Selected Licit and Illicit Drugs in Canada: 1985 & 1989

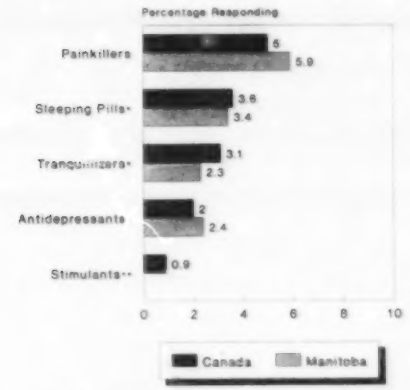



Source: Health Promotion Survey, 1985 & the 1989 NAD Survey.

In 1989, analgesic drugs, such as codeine, demerol and morphine; antidepressants; and diet pills and stimulants, were added to the national survey list, and the time-frame selected to measure "current use" was changed to the month before the survey.

In this ranking, analgesics were the most prevalent prescription psychoactive drug used by Canadians and Manitobans, followed by sleeping pills, tranquillizers, antidepressants and stimulants (Figure 2.7).

Figure 2.7 Use of Selected Licit Drugs During the Month Preceding the NADS Survey: Canada, 1989



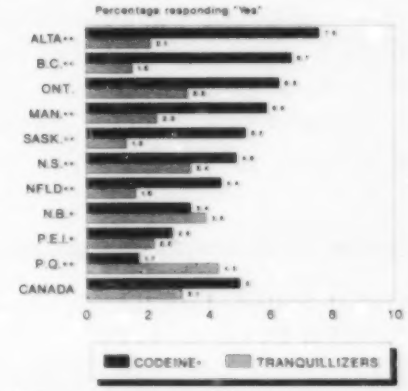

Source: NAD Survey, 1989; (*High Sampling Variability for Manitoba Data; **Supressed Data, Manitoba)

The proportions of Manitobans reporting the use of these drugs generally mirrors that of the national data. Consumption rates among Manitobans somewhat exceed the national average with regard to both analgesics and antidepressants, while national consumption rates exceed Manitoba's with regard to sleeping pills and tranquillizers.

## USE OF LICIT DRUGS VARIES BY PROVINCE

Analgesics such as codeine, demerol and morphine, and tranquilizers such as valium, appear to be consumed at relatively high levels within certain provinces.[7] According to the NAD study, in 1989 the highest usage rates for analgesics were reported in Alberta (7.6%), British Columbia (6.7%) and Ontario (6.3%). Manitoba reported the fourth highest rate of consumption, with

Figure 2.8 Population Reporting Current Codeine and Tranquillizer Consumption: Canada by Province




NAD Survey, 89 (*Incl. demerol/morphine) (**High sampling variability re tranqs; *re. tranqs and codeine; **re codeine)

5.9% of respondents to this study indicating that they "currently" consumed these substances. Nationally, five percent of study respondents indicated current consumption of analgesics. Prince Edward Island and Quebec reported the lowest current rate of consumption of analgesics, with 2.8% and 1.7% of these respondents reporting its use, respectively, one month prior to the administration of this study.

Conversely, the Province of Quebec reported the highest rate of consumption for tranquillizers, such as valium. In this case, 4.3% of respondents from this province reported the "current" consumption of this drug. This province was followed by New Brunswick, with a

consumption rate of 3.9%, and Nova Scotia (3.4%). Manitoba ranked fifth with regard to the reported consumption of tranquillizers, including 2.3% of study respondents from this province. The national consumption rate for tranquillizers, during this period, was 3.1%.

It is interesting to note that the provinces least likely to report high consumption rates for codeine appear more likely to report high consumption rates with regard to tranquillizers.

### SLEEPING PILLS ARE ALSO CONSUMED IN QUANTITY

Although they are not highlighted on the accompanying chart, consumption rates for sleeping pills exceed those of tranquillizers, both nationally and within some provinces. The national rate of consumption of sleeping pills, in 1989, was 3.6%.

The highest reported rate of consumption was again reported within the Province of Quebec, with 4.5% of these respondents reporting "current" consumption. This was followed by British Columbia with a consumption rate of 3.7%, followed by Ontario, Alberta and Manitoba, with a reported rate of consumption of 3.4%. Prince Edward Island and Saskatchewan reported the lowest consumption rate for sleeping pills (1.9%).

Data regarding Alberta, Manitoba, Prince Edward Island and Saskatchewan are subject to high sampling variability.

## 2.3 INTERNATIONAL COMPARISONS

### CANADIANS LESS LIKELY TO CONSUME ILLICIT DRUGS THAN THEIR AMERICAN COUNTERPARTS

Perceptions about the nature of drug use in Canadian communities are often influenced by impressions from the U.S. media. These perceptions are not necessarily valid. For instance, data from a 1990 American drug consumption survey show a higher usage rate for all illicit drugs surveyed when American and Canadian data are compared[8] (Table 2.1).

The U.S. data show that 33.1% of those surveyed reported ever having used cannabis and/or hashish: almost 10 percentage points above the Canadian lifetime rate of 23.2%. Current reported consumption of these drugs, for the American population (within the past 12 months) was 10.2%, compared with 6.5% of Canadian respondents.

Lifetime use of cocaine and/or crack is over three times higher in the U.S. than in Canada. Just under thirteen percent of American respondents reported ever having used either cocaine or crack, compared with 3.5% of their Canadian counterparts. Current usage rates for

cocaine in the U.S. of 3.1% are more than double the Canadian rate of 1.4%. The comparison of the rates with which other substances are consumed is more difficult, due to the way in which the information is captured in these two studies. For example, the Canadian study combines consumption data on LSD, speed and heroin, while the American study captures data on heroin alone.

**TABLE 2.1**
**A COMPARISON OF LIFETIME AND CURRENT CONSUMPTION OF ILLICIT DRUGS: CANADA AND THE UNITED STATES**

| | CANADA[9] ( 15+) | | | USA[10] (Ages 12+) | |
|---|---|---|---|---|---|
| SUBSTANCES | Ever Used | Past Year | SUBSTANCES | Ever Used | Past Year |
| Marijuana/Hashish | 23.2% | 6.5% | Marijuana/Hashish | 37.0% | 13.3% |
| Cocaine/Crack | 3.5% | 1.4% | Cocaine/Crack* | 12.7% | 3.6% |
| LSD/Speed/Heroin | 4.1% | 0.4%** | Heroin | 0.8% | 0.2% |

(*Cocaine and crack have been combined for the purposes of this table. In the original format they were listed separately. **High sampling variability.)

Notwithstanding this limitation, it also appears that American consumption rates regarding this class of drug is once again higher than that reported by Canadians, although current rates of consumption in both countries are relatively low.

## U.S., CANADA AND MEXICO TOP OTHER COUNTRIES IN COMPARATIVE DRUG CONSUMPTION

In a 1983 study related to the consumption of illicit drugs, the World Health Organization (WHO) undertook a comparison of drug use around the world (Table 2.2). While not providing a precise examination of this question, the data do provide qualitative information regarding the reported 'level of abuse' of six illicit substances within these countries.

The three countries which appear to have the highest levels of abuse, for all, or most, substances, are the U.S.A., followed by Canada and Mexico. In consideration of the six drugs cited (heroin, cocaine, cannabis, hallucinogens, amphetamines and barbiturates) all were seen to be extensively abused in the U.S.A., in 1980.

With one exception, all substances were also seen to be either extensively or moderately abused within Canada and Mexico. The exception relates to the use of heroin in Mexico which, at that time, was seen to be a 'minimal' problem for that country.

**Table 2.2**
**Comparative Drug Abuse, by Country, 1975-80**

| Country | Heroin | Cocaine | Cannabis | Hallucin. | Amphet. | Barbit./ Tranqs. |
|---|---|---|---|---|---|---|
| U.S.A. | 1 | 1 | 1 | 1 | 1 | 1 |
| CANADA | 2 | 2 | 1 | 2 | 1 | 1 |
| Mexico | 3 | 1 | 1 | 2 | 1 | 1 |
| Australia | 1 | 3 | 1 | 2 | 3 | 3 |
| Brazil | 4 | 2 | 1 | 3 | 2 | 2 |
| Italy | 1 | 3 | 1 | 3 | 3 | 3 |
| Japan | 3 | 3 | 1 | 3 | 1 | 3 |
| Argentina | 4 | 1 | 2 | 3 | 3 | 2 |
| Sweden | 2 | 3 | 1 | 4 | 2 | 3 |
| U.K. | 3 | 3 | 2 | 3 | 3 | 3 |
| France | 3 | 3 | 3 | 3 | 3 | 3 |

Key: Abusers per population. 1 = extensive abuse (>1:1,000) 2 = moderate abuse (<1:1,000 - 1:10,000); 3 = minimal abuse (<1:10,000 or verbal estimate; 4 = no abuse or no report.

Source: World Health Statistics Quarterly, 1983

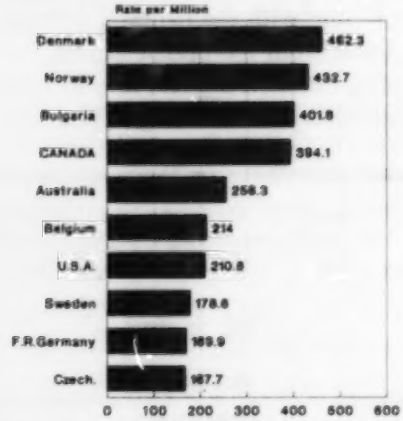
## CANADIANS FOURTH HIGHEST USERS OF CODEINE WORLDWIDE:

In 1985, Canada reported the fourth highest consumption rate of codeine, following Denmark, Norway and Bulgaria (Figure 2.9).

The rate of consumption in Canada was 394.1 milligrams per one million population. This rate is almost double that of the United States, which reported a rate of 210.8 milligrams per one million population.

According to the report **Codeine Consumption in Canada**, published by the Manitoba Pharmaceutical Association, the consumption of codeine is increasing much more quickly than population would account for. For example, between 1967 and 1987, the Association found that Canada's population had increased by 25.5%, while codeine consumption had increased by 188.4%.[11]

Figure 2.9 International Consumption of Codeine, per Million Population, 1985




(Source: Statistics on Drugs, Vol. II, Table 140, ARF, 1988.)

One of the primary reason cited for this level of usage is that Canada is one of the few countries where codeine is available without involving a medical practitioner (ie. no prescription is required for its purchase). Although products containing codeine are to be sold only by pharmacists in this country, and are not to be stored in public view within the pharmacy dispensary, it is the concern of the Association that there is an opportunity for the abuse of these products.

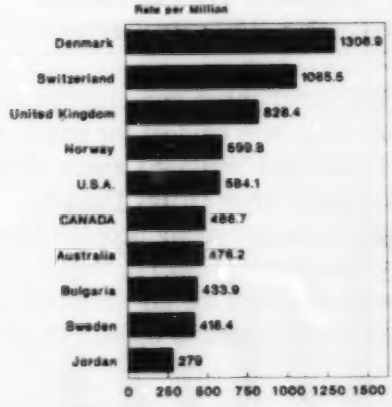
As a final note, it has been indicated that the Canadian data regarding codeine sales may be somewhat inflated, by virtue of the fact that Americans may be coming into Canada and purchasing products with codeine which are only available in the U.S. with a prescription.

This form of 'cross-border shopping' may account for sizable proportion of sales of these products within certain geographic centres of this country.[12]

## CANADA RANKED SIXTH IN THE CONSUMPTION OF ALL NARCOTIC DRUGS

In 1985, Denmark, Switzerland and the United Kingdom reported the highest consumption rates for all narcotics, according to the publication Statistics on Alcohol and Drug Use, (ARF, 1989) (Figure 2.10).

Figure 2.10 International Consumption of All Narcotic Drugs, per Million Population, 1985




(Source: Statistics on Drug Use, Vol II, Table 140, ARF, 1989.)

The consumption rate of all Narcotics in Denmark was 1306.9 per million population; 1065.5 per million in Switzerland; and 828.4 per million in the United Kingdom. The consumption rate among Canadians was 486.7 per million.

## 3.0 YOUTH AND DRUGS

For Canadian youth, the junior and senior high school years are often the years of greatest initiation and experimentation with both licit and illicit drugs, including alcohol. Parents, educators, researchers, governments and society in general tend to focus significant attention on understanding and influencing the drug using behaviours of this group. The concern is that a heavy commitment to drug use, established by some young people, may affect the patterns of use for the rest of their lives.

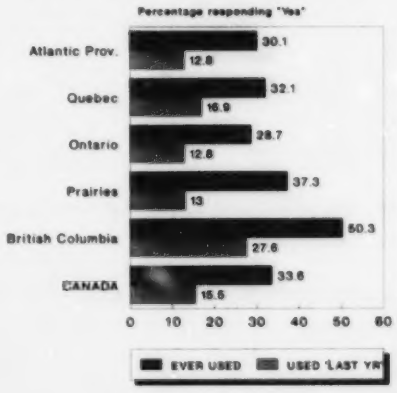
### BRITISH COLUMBIAN YOUTH MOST LIKELY TO CONSUME MARIJUANA AND HASHISH

Regional variations in consumption rates of various drugs was evident for youth. In the 1992 Health and Welfare Canada study, **Alcohol and Other Drugs Used by Canadian Youth**, young people (fifteen to twenty-four years of age) in British Columbia recorded the highest rates for lifetime use of cannabis or hashish (Figure 3.1).

While one-third of all Canadian youth participating in this study reported ever having used marijuana and/or hashish, just over half of those from British Columbia did so (50.3%).

The proportion of youth respondents from all other regions, who reported past consumption of these drugs, was generally more in line with the national average, with those from the prairie region reporting the next highest rate of lifetime consumption of these drugs (37.3%).

Figure 3.1 Marijuana and Hashish Consumption Among Canadian Youth (Ages 15 to 24) by Region: 1988




Source: Health and Welfare Canada, 1992

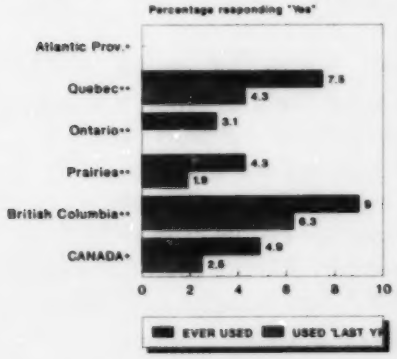
Considering current consumption of these substances, nationally 15.5% of youth respondents reported having used either marijuana or hashish during the year preceding the study (1988).

Once again, youth from British Columbia were almost twice as likely to report the current consumption of these substances compared with the national data, with 27.6% of these respondents reporting "current consumption." These were followed by youth from the Province of Quebec (16.9%); the prairies (13.0%); the Atlantic provinces and Ontario (12.8%).

## SMALLER PROPORTIONS OF YOUTH REPORT COCAINE AND CRACK CONSUMPTION

Nationally, just under five percent of the youth participating in this study reported ever having used either cocaine or crack (Figure 3.2). Regionally, youth from British Columbia were most likely to report lifetime consumption of these drugs (9.0%); followed by Quebec (7.5%); the prairies (4.3%); and Ontario (3.1%).

Figure 3.2 Cocaine or Crack Consumption Among Canadian Youth (Ages 15 to 24) by Region: 1988




Source: Health and Welfare Canada, 1992
(*Data suppressed. **High sampling variability. *High variab.'last yr' only)

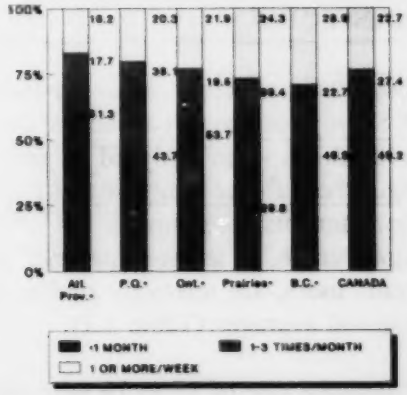
Related information regarding the atlantic region was suppressed by the study authors.

Nationally, only 2.5% of all youth in this study reported using cocaine or crack during the year preceding its administration. Regional data indicate that the highest proportion of those reporting "current" consumption reside in British Columbia (6.3%); followed by Quebec (4.3%); and the prairies (1.9%). Related data for Ontario and the atlantic provinces have been suppressed.

## FREQUENCY OF MARIJUANA AND HASHISH CONSUMPTION VARIES BY REGION

Of those youth who reported having consumed either marijuana or hashish during the twelve months preceding this study (ie. during 1988), the largest proportion stated that they did so less than once per month (Figure 3.3).[13]

Figure 3.3 Frequency of Marijuana and Hashish Consumption Among Canadian Youth by Region, During 'Last 12 Months'




Source: Health and Welfare Canada, 1992
(*High sampling variability.)

Nationally, 46.2% of eligible youth-respondents provided this response; while

27.4% indicated average consumption between once and three times per month; and 22.7% indicated consumption once per week or more often.

Regionally, youth from the atlantic provinces reported the least frequent consumption of marijuana and hashish, with 61.3% of these reporting consumption on a less than monthly basis.

At the other end of the spectrum, youth from the prairie provinces, who reported the "current" consumption of these drugs, were most likely to report consuming marijuana or hashish an average of once to three time per month (39.4%). Youth from British Columbia were most likely to report consumption of these substances on a weekly or more often basis (28.9%).

## HIGH RATES FOR YOUNG MALES IN MANITOBA

Although the rates recorded in the 1989 NAD Survey for use of cannabis show wide variations when analyzed by province and age, these figures suggest that the rates of cannabis consumption for Manitoba youth, in terms of past and "current" users, are relatively similar to the national averages (Table 3.1).

The Manitoba rate of 15 to 19 year old who reportedly ever used cannabis is 26.8%, somewhat higher than the average Canadian rate of 23.2. The rate of Manitoban "current users" in this age category is similar to the national average: 10.9% compared with 12.3%, respectively.

The percentage of 20 to 24 year olds who reportedly ever used cannabis, or are "current users" of this drug, are considerably higher than figures related to their younger counterparts. This is generally consistent across all provinces, and for the nation as a whole. Manitoba rates are once again somewhat higher than national averages.

It is noteworthy that, when gender is factored into this question, Manitoban males in this age category are much more likely to report ever having consumed cannabis: 65.1% compared with 49.4%, respectively.

Overall, British Columbians ages 15 to 19 were most likely to report lifetime consumption of cannabis (42.6%). Youth from British Columbia ages 20 to 24 were also most likely to report the lifetime consumption of this drug (57.8%); followed by Alberta (51.8%); Manitoba (49.6%); Newfoundland (43.0%); and Ontario (42.0%).

British Columbians ages 20-24 were most likely to report the "current consumption" of cannabis (28.6%); followed by Manitoba (19.1%); New Brunswick (18.6%); and Ontario (18.5%).

**AUTHORS' NOTE**: It was our intention to highlight Manitoba-wide youth studies, with particular attention being paid to regional consumption rates, attitudes and the information which youth currently have regarding the short and long-term effects

of varied drugs. From our research, it is obvious that there exists a need for Manitoba-wide research regarding youth alcohol and other drug consumption, along with youth attitudes and awareness of the consequences of drug consumption.

**Table 3.1**
**Cannabis Use Ages 15-24, Canada and the Provinces, 1989**

| | 15-19 Years of Age | | 20-24 Years of Age | |
|---|---|---|---|---|
| Region | Ever Used | Past Year | Ever Used | Past Year |
| NF | 10.2* | — | 49.0 | 17.0* |
| PEI | 15.2* | — | 34.8* | — |
| NS | 26.2 | 17.9* | 34.9* | 13.4* |
| NB | 15.9* | — | 51.7 | 18.6* |
| PQ | 28.6 | 17.4* | 35.2 | 16.7* |
| ON | 14.1* | 6.5* | 42.0 | 18.5 |
| MB | 26.8* | 10.9* | 49.6 | 19.1* |
| SK | 21.6* | — | 39.3 | 14.6* |
| AL | 26.4* | 10.2* | 51.8 | 17.1* |
| BC | 42.6 | 26.6* | 57.8 | 23.6* |
| Can. | 23.2 | 12.3 | 43.1 | 16.4* |

Source: HWC, National Alcohol and Other Drugs Survey, Canada, 1989 (Table 18, Supplementary Tables. (*High sampling variability.) (— = Data Suppressed)

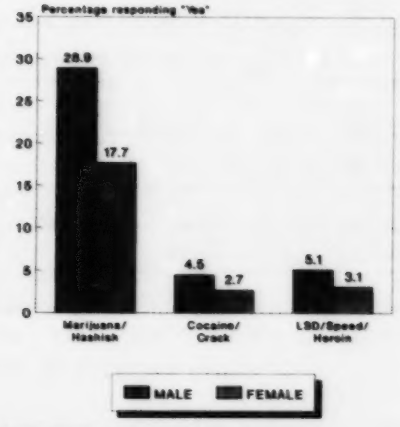
## 4.0 GENDER AND DRUGS

Men and women tend to select different psychoactive substances for consumption. In general, men are more likely than women to use alcohol and illicit drugs. Women are more likely than men to use prescription and over-the-counter drugs.

## MEN MORE LIKELY TO USE ILLICIT DRUGS

The 1989 NAD Survey reports that at all ages Canadian men are more likely than Canadian women both to have used illicit drugs in their lifetimes and to be current users of illicit drugs (Figure 4.1). Men appear almost twice as likely to report ever consuming marijuana and/or hashish, with 28.9% of male respondents reporting the consumption of these substances, compared with 17.7% of their female counterparts; cocaine and/or crack (4.5% of males compared with 2.7% of females); and LSD, Speed and/or heroin (5.1% compared with 3.1%).

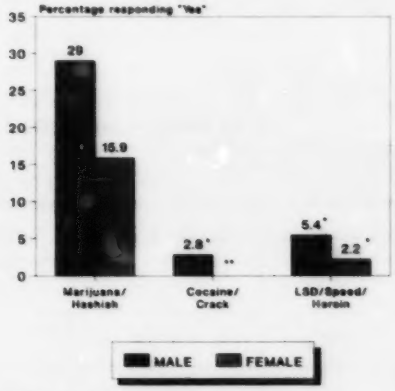
Figure 4.1 Lifetime Illicit Drug Consumption Among Canadians By Gender




Source: Health and welfare Canada, 1989

These lifetime trends also appear to apply to the Manitoba-based patterns of consumption of these substances (Figure 4.2).

Figure 4.2 Lifetime Illicit Drug Consumption Among Manitobans By Gender




Source: Health and welfare Canada, 1989 (*High Sampling Variability. **Data Suppressed.)

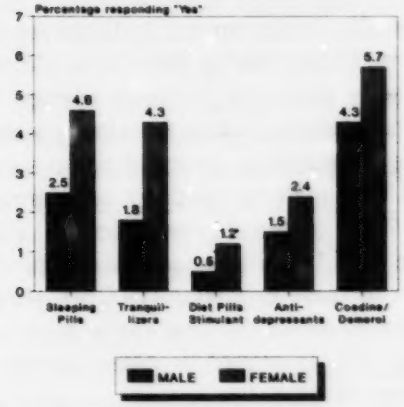
In this instance, the proportion of male and female respondents from Manitoba reporting the consumption of these substances almost parallels that of the national data.

## WOMEN MORE LIKELY TO USE LICIT DRUGS

When the consumption of licit substances is examined the trend noted above is reversed, at least at the national level (Figure 4.3). Of the five categories of licit drugs examined, women report greater consumption levels, during the month preceding the study, than did men. This is most pronounced with regard to the "current" use of sleeping pills, with 4.6% of female and 2.5% of male respondents reporting its consumption during this time-

frame; tranquillizers (4.6% compared with 1.8%); and diet pills or other stimulants (1.2% compared with 0.5%).

Figure 4.3 Consumption of Licit Drugs During the Month Before the Study By Gender: Canada



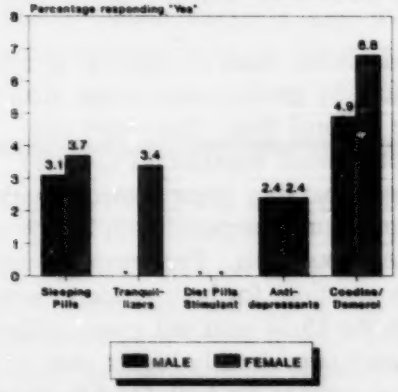

Source: Health and welfare Canada, 1989
(*High Sampling Variability.)

It is interesting to note that these trends appear less pronounced with regard to the Manitoba-based data (Figure 4.4). Excluding those licit substances for which the data has been suppressed (ie. tranquillizers for male respondents and diet pills or stimulants for respondents of both genders), the rate of reported consumption of the remaining drugs appears less varied by gender.

For example, the rate at which female respondents reported consuming sleeping pills, while lower than the national average for this substance, is generally not that different from the rate with which their male counterparts report its consumption. The rate with which antidepressants are reportedly consumed is identical by gender.

This finding may be reflective of an apparently lower rate of consumption of most of these licit drugs, among female respondents from Manitoba, as compared with national averages for this same population, along with a higher rate of related consumption reported by males from this province.

Figure 4.4 Consumption of Licit Drugs During the Month Before the Study By Gender: Manitoba




Source: Health and welfare Canada, 1989
(All Data Subject to High Sampling Variability. *Data Suppressed.)

## PROBLEMS ASSOCIATED WITH DRUG USE BY GENDER

In order to understand the perceived impact which drug consumption has upon others with whom drug users associate, the 1989 NAD Survey asked respondents

about the drug problems of their friends, families and co-workers. Emphasis in this section is on the degree to which gender appears to affect responses to these questions.

- **Friends with Drug Problem**:

Nationally, 24.6% of Canadian men and 19.3% of Canadian women said that they have had a friend with a drug problem. For all age groups, more men answered "yes" to this question than did women. The highest positive response rate for both men and women was in the 15-34 year old group (35.4% vs. 29.8%, respectively).

For Manitoba, rates of response to this question, by gender, were closer than that of the national data. Just under one quarter of male respondents (24.4%) indicated that they knew someone with a drug problem, compared with 20.1% of female respondents. Peak response rates to this question, for both genders, were also in the 15-34 year old group, although they were considerably higher than the national average for both (38.5% of males and 34.3% of females ages 15-34 years).

- **Family Members with Drug Problem**:

Nationally, when respondents to the NAD Study were asked if a family member had ever had a drug problem, 12.7% of Canadian men and 14.6% of Canadian women answered "yes." Respondents' ages do not generally appear to be a factor in this regard.

Manitoba data generally reflect a smaller proportion of respondents who reported drug problems among members of their families. For example, 7.9% of male respondents and 9.9% of female respondents reported drug-related problems among family members.

- **Co-workers with Drug Problem**:

Nationally, males appear to be aware of drug problems among their co-workers as they were aware of problems among family members, while females appear less aware of problems among their co-workers (15.4% of male respondents compared with 7.4% of female respondents). Men in the 35-54 year age range were most aware of these problems (19.2%), while women in the 15-34 year range were most aware of drug-related problems among co-workers (9.3%).

One possible explanation for these differential findings may be the fact that men are still more likely to enter the workforce than are women.

Overall figures for Manitoba were similar to the national averages. For all respondents from this province 14.2% of male, and 8.7% of female respondents reported being aware of a co-worker with a drug problem.

Age appears to be a factor affecting the reporting of related problems among co-workers for both males and females. For example, men in the 15-34 age group were most likely to report a co-worker with this problem (21.4%) compared with their female counterparts, of whom those in the 35-54 group were most likely to report this (11.2%). Both peaks were slightly higher

than the national average. (The data for this latter population is subject to high sampling variability.)

## WOMEN MORE LIKELY THAN MEN TO BE PRESCRIBED PSYCHO-ACTIVE DRUGS

Since the late 1970s, concern has been voiced that women are prescribed excessive amounts of psychotherapeutic drugs. Canadian researchers Ruth Cooperstock[14] and Susan Penfold[15] called attention to doctors' tendency to see women's complaints as symptoms of emotional and psychological problems and "treat the problems" with mood altering drugs. The result was to "silence and narcotize women" rather than to deal with the substance of the complaint.[16]

As recently as 1987, a study conducted at the Ottawa Hospital Family Medicine Centre showed that the ratio of women to men who were prescribed tranquillizers (381 patients out of 12,716) was 2.5:1.[17] This is consistent with the 1989 NAD Survey figures for Canada with a related ratio of 2.4 to 1. In other words, Canadian women are almost two-and-a-half times more likely as Canadian men in Canada to be current users of tranquillizers.

- Gender and Socio-Economic Factors:

Penfold has suggested that the high usage rates for women are linked to women with low social status who are locked into traditionally inferior positions in the workplace or in the family.[18]

Hill has suggested that women who hold full-time jobs, as well as carry out traditional domestic responsibilities, have more self-esteem and therefore are less likely to be users of psychoactive drugs than women who are underemployed or unemployed, or who are full-time care-givers or are retired.[19]

According to Holmstrom, doctors tend to prescribe tranquillizers and sleeping pills to women, and women continue to take them because the alternative of using large quantities of alcohol carries a large social stigma for women.[20]

## GENDER, VIOLENCE AND DRUGS

Research has also focused on women who use alcohol and other drugs as a way to adapt to physical or sexual abuse. In a conference sponsored by the Alcoholism Foundation of Manitoba in 1990, Dr. Stephanie Covington estimated that between 70% and 80% of women who have substance abuse problems have been sexually abused.[21]

Data supporting this perspective were also highlighted in a 1989 report published by the Addiction Research Foundation of Ontario. For example, ARF reports that

- Women sexually abused as children were three times more likely than

non-abused women to use medication to calm themselves, and twice as likely to use drugs to help them to sleep.

- Women sexually assaulted as adults were 2.4 times more likely to use drugs to help themselves sleep than non-abused women, and 3.7 times more likely to use medication to combat anxiety.

- Women subject to physical abuse as children by either parent reported 50% more use of medication to help them sleep and 100% more use of drugs for calming purposes than non-abused women.

- Battered women reported 40.5% use of medication to help them sleep, and 74% more use of medication to reduce anxiety.

Related ARF data on male batterers suggested that:

- Drug abuse was more likely among batterers than non-batterers.[22]

## OTHER FACTORS RELATED TO THE CONSUMPTION OF LICIT DRUGS AND GENDER

The highest use of **tranquillizers** by Canadians was reported by those with secondary education or less, by divorced and widowed females, and by those who had an income under $10,000 per year.[23]

The highest use of **sleeping pills** showed a similar pattern, with the use of these substances being most prominent among widowed persons.

With regard to **anti-depressants**, the pattern of lower education and income was again repeated for women. The highest reported rate of consumption for male respondents occurred for those who had some post-secondary education and earned between $10,000 and $19,999.

Users of **codeine** and other analgesics reflect a different pattern of consumption than that reported above. The highest rate of consumption of these substances is reported by men and women who have completed post-secondary education. The highest rate of analgesic consumption in men is reported by those earning in excess of $40,000 annually. For women, the highest rates of consumption is equally reported by those earning over $40,000 and those earning under $10,000 income.

One researcher has suggested that the choice of codeine for high income earners may in part be related to its effect on the user. For example, a codeine drug might be selected for someone who wanted to remain cognitively alert for work. In contrast, a tranquillizer such as Valium might be chosen for someone at home who, it is perceived, can manage the cognitively-impairing side effects.[24]
For Manitoba, 1989 NAD Survey figures are not available for most categories related to gender, education, income, or marital status.

## 5.0 SENIORS AND DRUGS

For a broad cross-section of the adult population of Canada, the "current" use of illicit drugs declines with age. In contrast, the use of psychoactive prescription drugs increases with age (Table 5.1).

According to the NAD Study, the use of **cannabis** peaks in individuals between the ages of 20-24, with 18.4% of these respondents reporting consumption of this substance. However, rates of consumption declines steadily to less than 2% for people 44 years and older.

In contrast with this observation, the probability of individuals reporting the use of sleeping pills and tranquillizers increases with age. People over the age of 65 are more than twice as likely (11.1%) to use sleeping pills than is someone in any other age group.

For women, tranquillizer use peaks in the 55-64 age group (9.6%) with a major increase occurring in the 45-54 age group (to 7.1% from 2.9% in the 35-44 year old group). After 65, the rate for women declines to 3.5%. For men, tranquillizer use peaks in the 65 plus age group at 6.8%.

**Table 5.1**
**"Current" Users of Drugs by Age, NADS 1989**

| Age | Alcohol | Cannabis | Cocaine/Crack | Sleeping Pills | Tranquillizers |
|---|---|---|---|---|---|
| | % Past Year | % Past Year | % Past Year | % Past Month | % Past Month |
| 15-19 | 74.3 | 12.3 | 1.9* | — | — |
| 20-24 | 87.9 | 18.4 | 3.1* | — | 1.4* |
| 25-34 | 86.9 | 10.5 | 3.3* | 1.3* | 1.4* |
| 35-44 | 83.1 | 4.5 | — | 2.4* | 2.6* |
| 44-54 | 76.5 | 1.2* | — | 4.5 | 5.0 |
| 55-64 | 72.1 | — | — | 4.8* | 6.0 |
| 65+ | 45.3 | — | — | 11.1 | 5.4 |

Source: National Alcohol and Other Drugs Survey, Canada, 1989. (*High sampling variability. — Data suppressed.)

## FACTORS ASSOCIATED WITH DRUG USE BY ELDERS

Everyone ages. Researchers, however, have pointed out that the elderly do not necessarily represent a homogeneous group. Instead, older people can be thought of as representing a wide range of behaviours, habits, thoughts, personalities, attitudes, values, and health conditions.[25]

Some people see aging as a series of losses and impairments. Gromberg lists seven major adaptations that may need to be dealt with as one ages.[26] If other coping measures used are inadequate or not available to seniors, then the following conditions may lead to the abusive use of drugs:

1. Role and status change;
2. Increase in chronic illness;
3. Cognitive changes, such as sensory loss and memory problems;
4. Retirement;
5. Widowhood;
6. Changes in social networks and social supports (death of friends, isolation, parent-child role reversals);
7. Individual style in reacting to loss (denial, disengagement, depression, or regrouping for continued activity and re-engagement) and overall life satisfaction.

In *successful aging*, Gromberg contends, loss and impairment may be minimized by factors such as nutrition, exercise, continued activity, and social involvement.[27]

## HEALTH, MEDICATION AND SOCIO-ECONOMIC STATUS INFLUENCE RISK OF DRUG ABUSE

Gromberg also suggests that the same factors that are associated with the use of health services by the elderly (ie. age, economic status, health condition, marital status, and living arrangements) are the same factors that are associated with the use of medication and alcohol.[28]

Even when there are significant environmental pressures to be dealt with, Gromberg suggests that it is often easier to write a prescription and ignore the environment than it is to modify someone's life situation.[29]

## HEIGHTENED EFFECT OF DRUGS IN OLDER PEOPLE

Several factors increase the impact of drug use in older persons including the fact that:

- The aging body contains less water, any drug taken will be experienced in a more concentrated form: reactions to dosage levels recommended for younger ages may be enhanced.

- Circulation and liver and kidney function slows down, the body gets rid of drugs at a slower rate: the effect of any drug may last longer.
- Some older people experience long term chronic illness and are likely to be taking drugs for a long time, dependency may develop.
- An older person may have more than one health condition and require several medications. The person may combine prescription drugs with over-the-counter drugs or alcohol, causing adverse drug interactions.

## ADVERSE DRUG REACTIONS CAN BE MISTAKEN FOR SYMPTOMS OF OTHER DISEASES

Problems caused by adverse drug reactions can be mistaken for signs of deteriorating physical or mental health in older people. Some of the signs include confusion, depression, anxiety, memory loss, sleep disturbances, incontinence, falls and burns. One study has warned that most prescribed drugs and many over-the-counter drugs can cause psychiatric symptoms in older patients.[30]

## OLDER HEAVY DRUG USERS LIVING IN MANITOBA

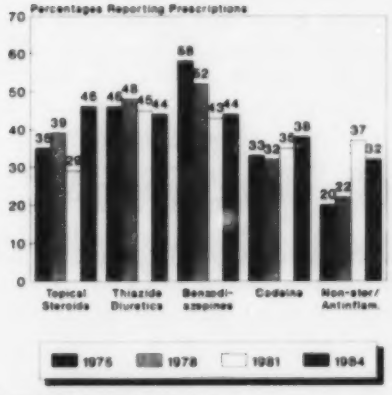
While survey data on drug use among the general population of elderly Manitobans does not exist, data does exist on two special subgroups: heavy prescription drug users living in the community over the age of fifty years; and heavy users of prescription drugs and alcohol, over fifty years of age, who are entering hospitals in Winnipeg.

**Heavy Users in the Community**:

One recent study (1991) considered adults aged 50 and over who used six or more prescription drugs per year, during 1975, 1978, 1981 and 1984.[31] Highlights of this study include the following data:

- The percentage of heavy drug users receiving prescriptions from five or more physicians declined from 9% to 6% over the decade in question.
- Although the literature predicts that women are prescribed more medication than men, by 1981 and 1984 there was no significant difference in the median number of drugs prescribed for older women as compared to older male heavy drug users (an average of 8 for both).
- The drugs prescribed most often in 1984 were topical steroids; thiazide diuretics; benzodiazepines; codeine; and non-steroidal anti-inflammatories (Figure 5.1). The proportion of individuals in this study population, who were prescribed topical steroids in 1984, was 46%; thiazide diuretics (44%); benzodiazepines (44%); codeine (38%); and non-steroidal anti-inflammatories (32%).

Figure 5.1 Selected Prescribed Drugs in Manitoba Among Individuals Fifty Years and Older: 1975-84




Grymonpre, R. et al, "Prescribing Patterns for Older Heavy Users in the Community" (1988)

- Although the prescribing of benzodiazepines decreased over the ten year period from 1975 through 1984, this drug remains one of the five most commonly prescribed drugs. Prescriptions for thiazide diuretics and codeine generally did not change during this period, although there was a rise in the rate with which non-steroidal anti-inflammatories were prescribed.[32]
- Over the decade, a larger proportion of women were prescribed psychoactive drugs, including benzodiazepines, antidepressants, barbiturates, and phenothiazines (anti-psychotic agent).

**Medications and Hospitalization:**

A 1988 study focused on persons aged 50 and older with non-elective medical admissions to the Winnipeg **Health Sciences Centre.**[33] Study highlights included:

- Of 863 admissions, 162 or 19% exhibited at least one drug-related adverse patient event (DRAPE).
- Of the 162 DRAPES, ninety-three, or 48%, were due to an Adverse Drug Reaction (ADR) to the doses normally used in humans.
- Females had significantly more adverse drug reactions although sex was not a predictor for overall DRAPE risk.
- The risk of a DRAPE was related to the number of drugs for which an individual was prescribed, and not related to age.

## CHEMICAL DEPENDENCY IN ELDERS USING HOSPITAL EMERGENCY SERVICES IN WINNIPEG

In 1988, a research project at Winnipeg's **St. Boniface Hospital** explored the prevalence of chemical dependency problems in people over 64 years of age, who made use of the hospital emergency room.[34] This investigation showed that:

- 29.6% of the patients in this sample required some form of intervention for chemical dependency.
- Of those who tested positive for benzodiazepine, females represented 73.3% of this population, and males 26.7%.

- Of those who tested positive for opiates (codeine, demerol, morphine), females represented 73.3% of this population and males 25.7%.
- Conversely, of those who tested positive for alcohol, 65.4% of this population were male and 34.6% were female.

The St. Boniface research project also consisted of intervention and treatment components. One conclusion of the intervention stage was that patients were more likely to accept interventions when their family and friends had already recognized the dependency.

On the other hand, significant barriers to intervention were encountered when family, friends or other social support networks denied the problem, or helped the person to continue his or her abusive behaviour.

It is believed by these authors that, perhaps due to the stigma of chemical dependency or a fear of institutionalization, or intense feelings of guilt and shame, older people do not often wish to participate in traditional chemical dependency programs.

To overcome such barriers, the St. Boniface **Elders Health Program** used a self-help group structure that was facilitated by a peer counsellor of a similar age-group and by a professional social worker as a co-therapist.[35]

### RECOVERY FROM DRUG DEPENDENCY IN THE ELDERLY IS LINKED TO QUALITY OF LIFE ISSUES

One finding of the Elders Health Program was that recovery in the elderly is intrinsically connected to quality of life issues. Forty percent of the referrals for treatment had to do with anxiety, sleeplessness, or depression. People in the treatment group also had significantly higher scores for loneliness and depression, lower scores in life satisfaction and higher scores for major health risks. Common issues that arose in the group were loneliness, social inactivity, multiple losses, resentments and unresolved grief.[36]

## 6.0 PHARMACEUTICAL DRUGS

The domestic market for medical and pharmaceutical products was estimated by Statistics Canada to be worth $4,218.4 million in 1990. That dollar figure represents a 30% increase in revenue over the previous five years.

In a 1990 survey focused on ethical

medicines, Health and Welfare Canada found that the following percentages of the population, used prescription drugs in the past year:[37]

- 22.4% of respondents reported that they used the drugs often.
- 22.4% occasionally
- 24.5% rarely
- 30.6% not at all.

The most frequently used over-the-counter drugs, and the percentage of the population who reported using them are as follows:

- **Pain relievers**: 12% of respondents used them often; 39% occasionally.
- **Cough and cold remedies**: 37% of respondents used them occasionally.
- **Vitamins and minerals**: 22% of respondents used them occasionally.
- **Upset stomach and nausea remedies**: 20% of respondents used them occasionally.

## PRESCRIPTION DRUGS IN MANITOBA

Although survey data on the use of ethical medicines by the general population of Manitoba are not available, the province has established a new **Multiple Prescription Program**. The primary objectives of this program are to track:

- Specific consumers whose drug use requires intervention;
- Specific prescribers who may require re-education and/or intervention; and
- Trends of drug use which suggests the need for public/professional education regarding more responsible drug use.[38]

In 1990, the Program recorded a total of 51,585 prescriptions issued by Manitoba medical practitioners. Of these, individual doctors accounted for 50,824 prescriptions; dentists for 729; and veterinarians for 32. Those issued in hospitals and personal care homes were not covered.

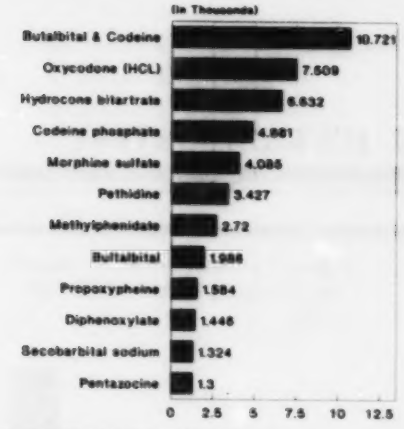
## PROGRAM REPORTS DECLINE IN USE FOR MOST REGULATED DRUGS

During its first year (1990), the program saw a 34% reduction in prescriptions for the monitored drugs, with an estimated $800,000 reduction in drug costs.[39] The top twelve drugs monitored during 1990 are shown in Figure 6.1 (page opposite).

## PROGRAM MAY INFLUENCE PRESCRIBING PATTERNS

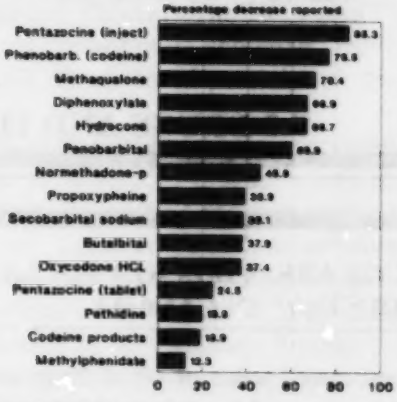
A number of dramatic decreases in prescription medications being prescribed have occurred following the creation of the Multiple Prescription Program.[40]

Figure 6.1 Numbers and Types of Prescriptions Filled in Manitoba: 1990




Source: Manitoba Multiple Prescription Program, Annual Report 1990.

Figure 6.2 Percentage Decrease in the Quantities of Prescription Medications Prescribed from 1989 to 1990




Source: Survey of 22 community pharmacies, Annual Report, Manitoba Multiple Prescription Program, 1990

Between 1989 and 1990, there is an 85.3% reported reduction in the prescription of (injectable) Pentazocine; a 76.5% decrease in the prescription of Phenobarbital with codeine; a 70.4% decrease in the prescription of Methaqualone; a 66.9% decrease in the prescription of Diphenoxylate; and a 66.7% overall decrease in prescriptions for Hydrocodone (Figure 6.2).

Conversely, the use of morphine containing products has increased; these drugs are used primarily for cancer patients or chronic pain syndromes.

Two anorexiant drugs were added to the list of monitored drugs in July 1991. Codeine compounds and benzodiazepines were also considered, but not included because of the high volume of data that they would require the new program to process.

## PROGRAM IDENTIFIES JUSTICE ISSUES

Other results of the Multiple Prescription Program include:

- Identifying 93 patients whose drug use appeared to require intervention, including 48 patients who were receiving prescriptions from more than one physician.
- Issuing 45 requests to physicians for indications for prescribing.
- Reducing forged prescriptions to zero for drugs covered under the program and recorded on the new "triplicate" form. (One copy of the form is sent to the Multiple Prescription Program for entry

into a comprehensive, computer database; the original is retained by the pharmacist and one copy is retained by the prescriber).

- Reducing the turn around time for reporting potential abuse to 7-14 days from 6-12 months.[41]

## 7.0 DRUGS AND THE CRIMINAL JUSTICE SYSTEM

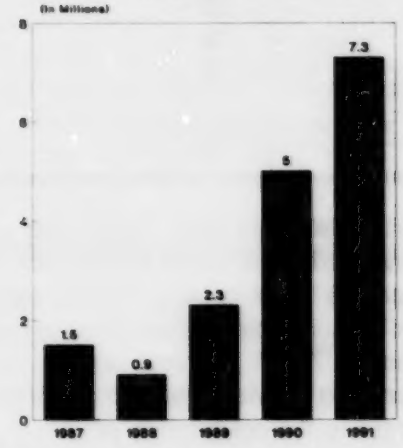
### DRUGS ARE A BILLION DOLLAR "INDUSTRY" IN CANADA

The estimated value of illicit drugs in Canada ranges from a low of between $1.5 to $2.9 billion (Gupta, 1987), and $2 to $3.2 billion (McCracken, 1987), and up to a maximum of $10 billion (RCMP, 1985).[42]

In 1991, the Winnipeg Police Department estimated that the street value of the drugs they seized were worth $7.3 million, up from $1.5 million in 1987 (Figure 7.1).

In 1990, the largest volume of drugs seized (182,307 grams) was for marijuana (wet exhibits) with an estimated street value of $820,381. The smallest volume seized was for crack cocaine (2 grams) with a total value of $320 (Figure 7.2).

Figure 7.1 Value of Drugs Seized by Winnipeg Police, 1987-1991

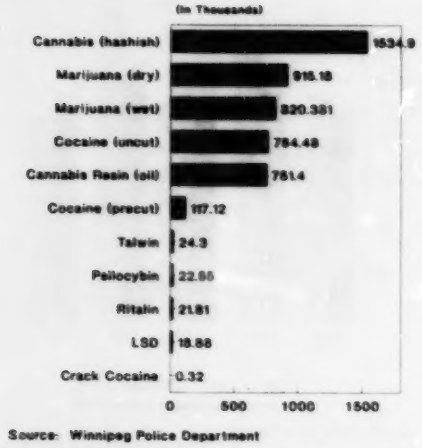



Source: Winnipeg Police Department

### QUALIFICATIONS PLACED ON JUSTICE STATISTICS[43]

Because certain types of drug use are defined by law to be illicit, the data recorded by the justice system represent only a portion of the drug activity that actually takes place; some level of drug activity remains hidden. Justice statistics also reflect the focus of various government departments in alloca-ting resources to specific areas of drug control. If a police department, for example, chooses to focus on trafficking rather than possession, then departmental statistics will likely record an increase in trafficking charges, and a decrease in possession charges, all other factors remain unchanged.

Figure 7.2 Value of Drugs Seized by Winnipeg Police by the Types of Drugs Seized: 1990




Source: Winnipeg Police Department

In addition, justice statistics for criminal offences also record only the most serious violation within a criminal incident. For example, if a violent crime and a drug crime are committed with the same incident, the incident is classified as a violent offence and the drug offence is not counted. Similarly, if a trafficking offence and a possession offence occur within the same incident, the trafficking offence is recorded and the possession offence is not recorded.

## THE FEDERAL DRUG LAWS DEFINE ILLICIT USE OF DRUGS

The two federal statues that deal specifically with illicit drugs are the **Narcotic Control Act** (NCA) and the **Food and Drug Act** (FDA).

The NCA prohibits and sets penalties for the possession, trafficking (sale), importation, and cultivation of over 100 substances, including: cannabis, heroin, cocaine and Talwin. The NCA also prohibits "prescription shopping" for primarily opium-based prescription drugs.

Part III of the FDA governs accessibility to certain "controlled drugs," which are used both for medical and non-medical purposes. These drugs include sedative-hypnotics like Halcion and Seconal, tranquillizers like Valium, and stimulants like Dexedrine and Ritalin. Simple possession of controlled drugs is not an offence. Possession for the purpose of trafficking, unauthorized sale and prescription shopping are offences.

Part IV of the FDA governs the use of "restricted drugs" such as LSD, MDA, psilocybin and other hallucinogens, which are not generally used for medical purposes. Possession and sale of these drugs are offences.

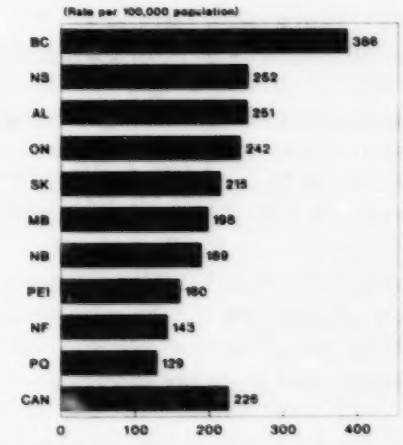
## MANITOBA DRUG CRIME RATE LOWER THAN THE NATIONAL AVERAGE

In 1990, drug offences accounted for less than 2% of all criminal offences reported by police both in Canada (1.9%) and in Manitoba (1.7%).

The number of actual drug offences in Canada was 60,039 or 226 offences per 100,000 population. In Manitoba, the

number of offences was 2,165 or 198 offences for each 100,000 people (Figure 7.3).

Figure 7.3 Drug Crime Rates in Canada and the Provinces, 1990



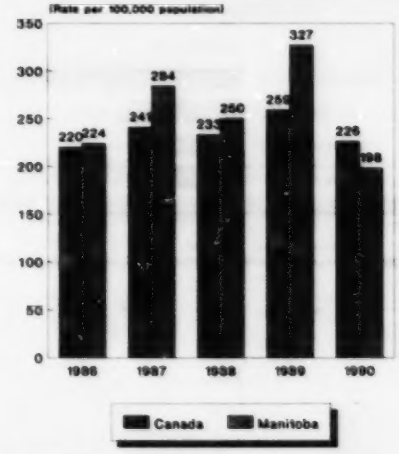

Source: Statistics Canada

In 1990, Manitoba had the fifth lowest incident rate among the ten provinces (198 per 100,000 population). B.C. had the highest (386), and Newfoundland the lowest (143).

Rates declined for all provinces from the year before, except for Newfoundland, PEI and Nova Scotia.

During the last five years, Manitoba drug crime rates mirrored the national crime rates with peaks in 1989 and 1987. The drop to 198 in 1990 from a high of 327 in 1989, represents the first time in five years that Manitoba has been below the national average (Figure 7.4).

Figure 7.4 Drug Crime Rates for Canada and Manitoba, 1986-1990




Source: Statistics Canada

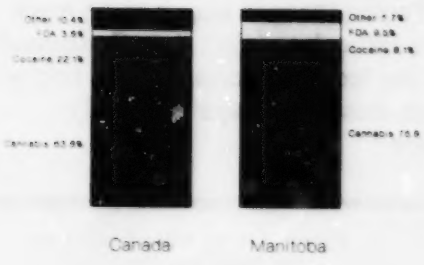
## OFFENCES BY DRUG TYPE

The proportion of cannabis offences is higher for Manitoba than for the country as a whole (76.8% and 63.8%, respectively), while the proportion of cocaine offences in Manitoba is lower (8.1% and 22.1%, respectively) (Figure 7.5).

Heroin-related offences in Manitoba were negligible.

The proportion of offences recorded under the **Food and Drug Act** is almost three times as large for Manitoba as it is for Canada as a whole (9.5% and 3.8%, respectively).

Figure 7.5 Total Offences by Types of Drugs: Canada and Manitoba, 1990




Source: Statistics Canada

## SMALL VARIATION IN MANITOBA OFFENCE RATES FOR CANNABIS

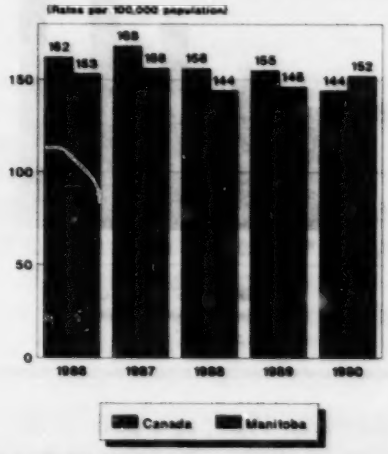
Over the past five years the offence rate for cannabis in Canada has declined from a peak of 168 per 100,000 population in 1987, to a low of 144 offences per 100,000 population in 1990 (Figure 7.6).

For Manitoba, the pattern was somewhat more variable, with a five-year low occurring in 1988 at 144 offences per 100,000 population.

The 1990 rate for Manitoba was 152 per 100,000, slightly higher than the national average for that year.

During this five year period, the average national per capita offence rate was 157 offences per 100,000 population, compared with an average Manitoba offence rate of 150.2 per 100,000 population.

Figure 7.6 Cannabis Offence Rates for Canada and Manitoba: 1986-1990



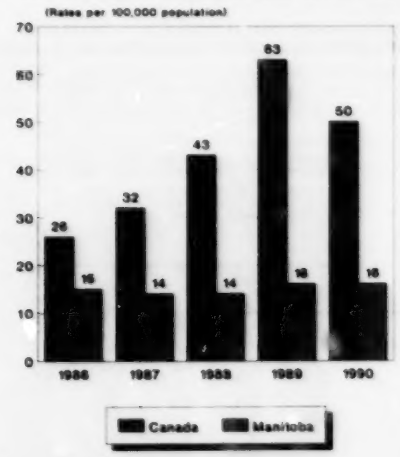

Source: Statistics Canada

## COCAINE OFFENCE RATES IN MANITOBA MUCH LOWER THAN NATIONAL RATES

In contrast to the preceding data, Manitoba reports notably lower offence rates with regard to cocaine, than does Canada as a whole (Figure 7.7). For example, while the Manitoba offence rate for this drug has remained fairly constant, at between 14 and 16 offences per 100,000 population, the national rates have been both much higher, and more variable over this period.

Nationally, rates have ranged from a low of 26 related offences per 100,000

Figure 7.7 Cocaine Offences Rates for Canada and Manitoba: 1986-1990




Source: Statistics Canada

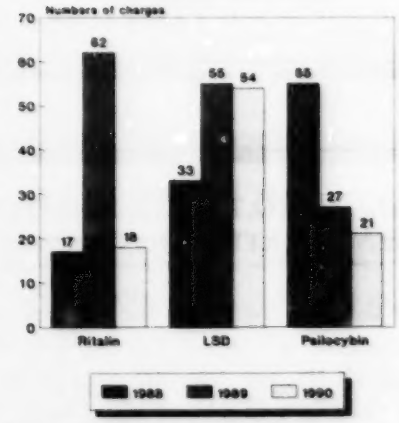
population in 1986, to a peak of 63 offences in 1989. The average rate of offences, per 100,000 population, over this reporting period, was 15. The average rate, nationally, was 42.8.

## DRUG CHARGES IN WINNIPEG UNDER THE FOOD AND DRUG ACT

Between 1988 and 1990, Winnipeg-based charges, under the FDA, were most often made with regard to: Ritalin, L.S.D., and psilocybin (Figure 7.8). The number of charges laid regarding Ritalin peaked in 1989; the number of charges regarding LSD have remained constant from 1989 and 1990; and there has been a steady decrease in the number of charges related to psilocybin.[44]

Talwin and Ritalin, injected in combination, became an area of concern during the mid-1980s. However, in January 1990, one form of Talwin (Compound 50) was taken off the market due to this abuse, leaving Talwin Plain. As Talwin Plane is known to be much more difficult to inject than Compound 50, this has led to a decrease in the rate with which these two drugs are jointly abused.[45]

Figure 7.8 Charges Laid Under the Food and Drug Act: Winnipeg, 1988-1990



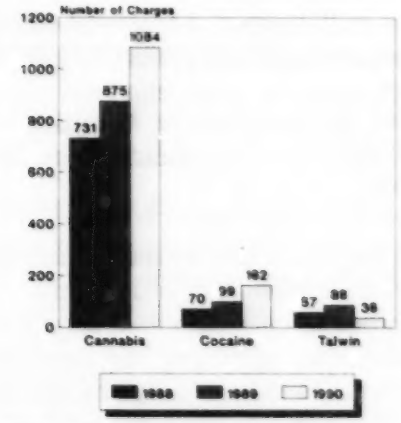

Source: Winnipeg Police Department

## DRUG CHARGES IN WINNIPEG UNDER THE NARCOTICS CONTROL ACT

There has been a steady and dramatic increase in the number of reported charges, in Winnipeg, related to cannabis between 1988 and 1990. In 1988 Winnipeg

Police reported 731 cannabis-related charges. In 1990 this figure rose to 1,084: an increase of 28%.

Figure 7.9 Charges Laid Under the Narcotics Control Act: Winnipeg, 1988-1990




Source: Winnipeg Police Department

Although the absolute number of convictions for cocaine are substantially smaller than those reported for cannabis, the percentage increase of cocaine-related convictions more than doubled during this period.

In 1988 Winnipeg Police reported 70 cocaine-related charges. By 1990 this figure had jumped to 162. This represents an increase of 56.8%

## CHARGES LAID FOR PRESCRIPTION DRUG OFFENCES

Drug offence convictions for multiple doctoring of pharmaceuticals increased until 1985, and since then have accounted for over half of the total offence convictions in Canada. Convictions related to the illegal importation of pharmaceuticals have remained nil or negligible through the 1980s and 1990s.[46]

Of the total charges related to pharmaceutical drugs in 1990, 55% resulted in a conviction (down from 68% in 1988).

Of the total convictions, only one-third resulted in a custodial sentence. Forty-five percent of convictions were suspended sentences, probation or discharges. The majority of these convictions in 1990 involved opiods (91%), with codeine comprising 45% of these. Stimulants and hypnotics accounted for only 9% of all convictions.

## ENFORCEMENT TARGETS SUPPLY OFFENCES

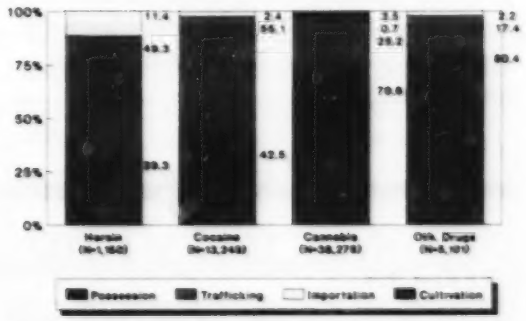
Supply offences (trafficking, importation, and cultivation) account for a much larger proportion of illicit drug-related crimes than they did in the past, according to a study undertaken by Statistics Canada.[47]

In 1990, there were a total of 57,776 offences recorded in Canada. Of these, **cannabis** constituted 38,276 offences (66.3%); **cocaine** 13,249 (22.9%); and **heroin** 1,150 (2.0%). In addition, 5,101 offences (8.8%) were related to **other drugs**.[48]

Of the total charges, **possession** accounted for 37,191 offences (64.4%); **trafficking** for 18,410 offences (31.9%); **importation** for 832 offences (1.4%); and the **cultivation of marijuana** for 1,343 offences (2.3%).

Analyzing these data by the primary drugs reported in Canada in 1990, the highest proportion of offences regarding heroin and cocaine related to the trafficking of these drugs (49.3% and 55.1% respectively, of all offences reported) (Figure 7.10).

Figure 7.10 Type of Offences by Drug of Choice: Canada, 1990




Source: Statistics Canada

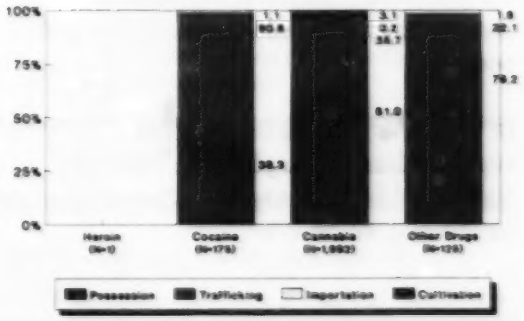
With regard to offences related to cannabis and "other drugs," the highest proportion of offences, during this period, related to possession of these substances (70.6% and 80.4%, respectively, of all offences reported).

In 1990, Statistics Canada, in its Canadian Crime Statistics Report[49] found that there were 1,960 drug-related offences in Manitoba. Of these, 175 (8.9%) were related to cocaine; 1,662 (84.8%) were related to cannabis; and 122 (6.2%) were related to "other drugs." Only one heroin-related offence was reported for Manitoba in 1990.

The overall number of Manitoba-based offences for trafficking was 727 (37.1% of all offences); for importation was 7 (0.4%); for cultivation of marijuana was 52 (2.6%); and for possession was 1174 (59.9%).

Analyzing these data by the primary drugs reported, in Manitoba, in 1990, the proportion of charges related specifically to possession, trafficking and importation are similar to those reported nationally (Figure 7.11).

Figure 7.11 Type of Offences by Drug of Choice: Manitoba, 1990




Source: Statistics Canada

The highest proportion of offences

regarding cocaine related to the trafficking of this drug (60.6%), followed by possession (38.3%) and importation (1.1%). For cannabis and "other drugs," the highest proportion of charges related to possession (61.0% and 76.2%, respectively).

## MULTIPLE DOCTORING OFFENCES IN MANITOBA VARY BY REGION

Multiple doctoring occurs when a person obtains a narcotic or controlled drug from one or more physicians within a 30-day period without informing the prescribers; a licit drug diversion offence.[50] In 1990 the rate of convictions in Manitoba for multiple doctoring is estimated as 1 per 100,000 population. This compares to a national rate of 3 per 100,000 population.[51]

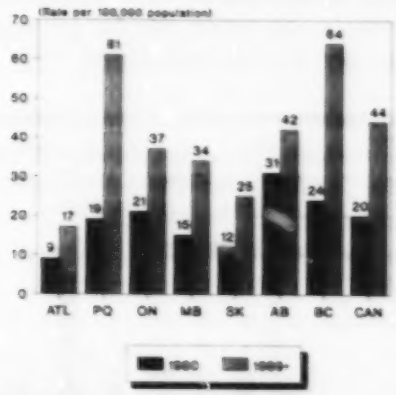
During 1990 the RCMP reported 867 multiple doctoring offences in Manitoba. Winnipeg reported 773 offences, Beausejour 67, Thompson 25 and Steinbach 2.

## CONVICTIONS FOR DRUG CRIMES INCREASED IN MANITOBA

Between 1980 and 1989, the drug conviction rate (excluding cannabis) had increased in every province and nationally. For Canada as a whole, the rate increased from 20 per 100,000 in 1980 to an estimated 44 per 100,000 in 1989: an increase of 54.5% (Figure 7.12).

In Manitoba, the conviction rate for drug crimes (excluding cannabis) more than doubled from 15 convictions per 100,000 population in 1980 to an estimated 34 per 100,000 in 1989.

Figure 7.12 Drug Conviction Rates For Canada and the Provinces: 1980 and 1989•




Source: Bureau of Dangerous Drugs
Note: Rates exclude convictions for cannabis; (•estimated)

The highest estimated rates of increase were reported for Quebec and British Columbia. Regarding the former, the rate went from 19 per 100,000 to an estimated 61 per 100,000 during this period. In terms of the latter, the rates increased from 24 per 100,000 in 1980 to an estimated high of 64 per 100,000 in 1989.

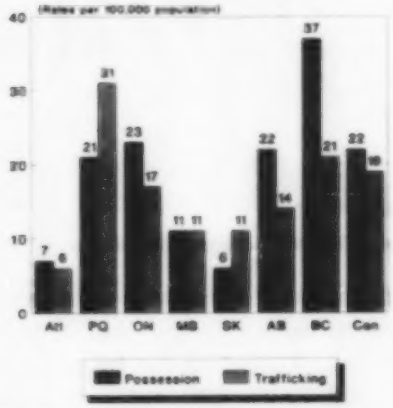
## CONVICTIONS VARY BY PROVINCE

As shown in Figure 7.13, the 1990

conviction rates for simple possession are larger than the rates for any other category except in Quebec, Saskatchewan and Manitoba.[52]

The highest conviction rate for possession occurred in British Columbia, with 37 convictions for every 100,000 population. The lowest rate was in Saskatchewan, with a conviction rate of 6 per 100,000 population, followed by Atlantic Canada with a rate of 7 per 100,000 population. Manitoba's conviction rate for possession was 11 per 100,000 population.

Figure 7.13 Drug Conviction Rates by Types of Offence for Canada and the Provinces: 1990•




Source: Bureau of Dangerous Drugs, 1991
(•Estimated)

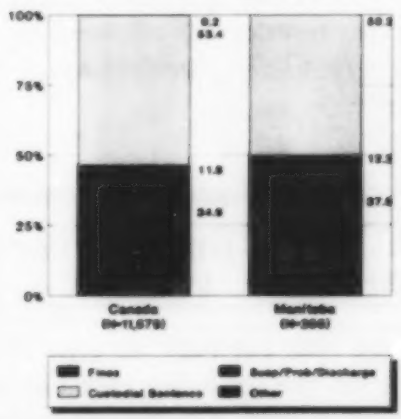
Conviction rates for trafficking are highest in Quebec (31 per 100,000) and lowest in Atlantic Canada (6 per 100,000 population). Manitoba's conviction rate for trafficking was, once again, 11 per 100,000 population.

Comparing the disposition of charges for Canada as a whole and Manitoba, under the Federal Drug Legislation, the largest proportion of these charges resulted in custodial sentences.[53] With regard to the Canadian figures, of the 11,579 convictions under this legislation, 6,187 (53.4%) resulted in custodial sentences (Figure 7.14).

Of the remainder, 1,363 (11.8%) were suspended, placed on probation, or otherwise discharged; while 4,012 (34.6%) received fines. Seventeen (0.2%) resulted in other actions.

The disposition of these charges within Manitoba are proportionately very similar to the national figures. Of the 255 charges laid in Manitoba, 128 (50.2%) resulted in custodial sentences; 31 (12.2%) in suspensions, probation or discharge; and 96 (37.6%) in fines.

Figure 7.14 Distribution of Sentences Canada and Manitoba, 1990•




Source: Bureau of Dangerous Drugs, 1991
(•Estimated)

# 8.0 The ALCOHOLISM FOUNDATION OF MANITOBA

## 8.1 MANDATE

The AFM is the provincial authority responsible for providing prevention and treatment programs related to chemical misuse and dependency to individuals and communities; conducting research into the negative effects of substance abuse; and in so doing, promoting the health and well-being of Manitobans.

The AFM has three primary roles in the community:

- As a **service provider**, the AFM conducts intervention, prevention, treatment, rehabilitation, research and evaluation programs, including public education and training services. Its facilities include five residential treatment centres and 19 service delivery offices.

- As a **sponsor and funder**, the AFM enters into agreements with, and makes grants to, government and non-government agencies conducting activities consistent with the mission of the Foundation. In 1991/92, nine agencies have a continuing funded relationship with the AFM.

- As a **leader**, the AFM provides expertise, encouragement and motivation to the community, government and non- government agencies in addressing the problems associated with chemical misuse and dependency; and thereby promotes the health, independence and potential of Manitobans.

## 8.2 CLIENT PROFILE

The Alcoholism Foundation of Manitoba maintains a management information system called the **Uniform Data System** (UDS). The UDS tracks information related to client profiles, presenting problems and treatment history. This last piece of data is collected at the point at which a client leaves the AFM.

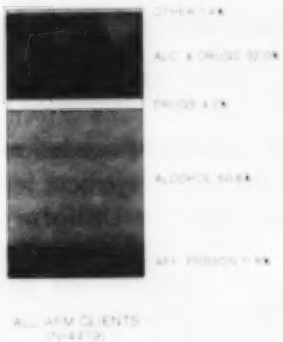
This section of ***FASTFACTS*** provides a brief profile of AFM clients, with special emphasis being placed on those clients reporting the consumption of drugs other than alcohol. The UDS collects data regarding all clients of the AFM, as well as the clients of the nine agencies which receive funding from the Foundation. The data which follow relate to AFM clients only.

**Alcohol is Largest Presenting Problem for AFM Clients:**

In 1990/91, 50.6% of AFM clients were classified as having "alcohol" as their sole problem; 32.0% reported having both "alcohol and other drug" problems; 11.8%

were "affected" by some other person's problem; 4.2% had reported problems solely with "drugs"; and 1.7% were classified as experiencing "other" related problems (Figure 8.1).

Figure 8.1 AFM Client Profile
Presenting Problems: 1990/91

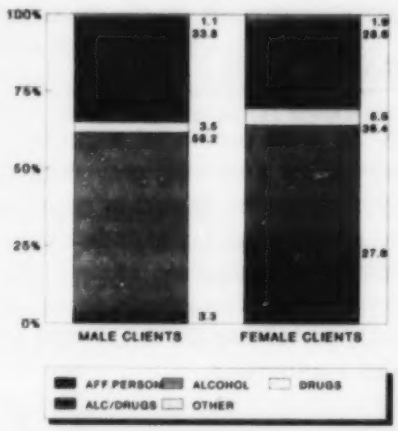


Source: AFM Annual Statistical Review

## A Higher Proportion of Men Have Problems with Alcohol or Alcohol and Drugs:

Client problems vary with gender. Women are considerably more likely than men to be involved with the AFM by virtue of their being an "affected person" (Figure 8.2). In fact, while 27.6% of women were affected persons in AFM programs, only 3.3% of their male counterparts fell in this category. Conversely, men are much more likely to attend programs for problems related to alcohol only; and because of problems with alcohol in combination with

Figure 8.2 AFM Client Profile
Presenting Problem by Gender 90/91




Source: AFM Annual Statistical Review

other drugs. The proportion of clients reporting problems solely with drugs does not seem to vary much by clients' gender.

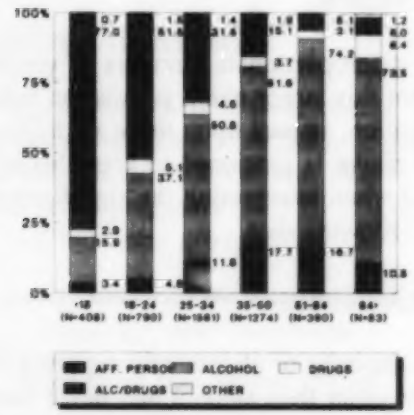
## Presenting Problems Vary Greatly By Age:

Client profiles vary greatly, depending upon the ages of AFM clients (Figure 8.3). These variations are most pronounced regarding the proportion of clients reporting the consumption of drugs other than alcohol. For example, as clients age, they appear to be more likely to report the consumption of alcohol only. Percentages range from 15.9% of clients ages seventeen and under who report the sole use of alcohol, up to a maximum of 74.2% and 73.5% of clients in the 51-64 and over 64 year ranges, respectively.

Similarly, the younger clients are, the more likely they appear to be to report the

use of drugs other than alcohol. Just under eighty percent of clients under the age of eighteen reported the use of drugs and alcohol, or drugs only, compared with 14.4% of client over sixty-four years of age.

Figure 8.3 AFM Client Profile
Presenting Problem by Age: 1990/91




Source: AFM Annual Statistical Review
(Multiple responses are possible.)

Clients in the thirty-five to sixty-four year ranges appear most likely to report involvement with the AFM as an Affected Person. On the other hand, there does not appear to be a strong relationship between client ages and the likelihood that they report the sole use of drugs other than alcohol. The range for this category is from a low of 2.9% of those under the age of eighteen, to a maximum of 5.1% of client between eighteen and twenty-four years of age.

## Drugs of Choice of AFM Clients:

Among those AFM clients who reported using drugs other than alcohol, the primary drug of choice is **cannabis** (Figure 8.4). This is a multiple response question. Of the 3069 responses related to drugs used by AFM clients in 1990/91, cannabis was identified by 47.4%.

The next most frequently identified drug was **cocaine**, with 14.2% of these clients selecting this substance. Among prescription drugs, the top three drugs of choice for AFM clients were tranquillizers (9.7%), narcotic/analgesics painkillers (5.3%) and sedative/hypnotic sleeping pills (2.8%).

Figure 8.4 AFM Client Profile
Drug of Choice for Clients Consuming
Drugs Other Than Alcohol: 1990/91

Source: AFM Annual Statistical Review
(Multiple responses are possible.)

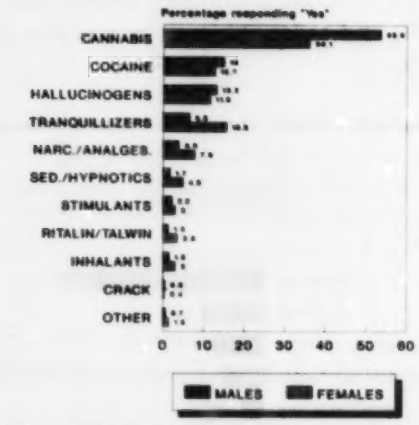
## Drug of Choice Tends to Vary by Gender:

Male and female clients reportedly prefer using different substances (Figure 8.5). Male clients are much more likely to

report the use of cannabis than are their female counterparts.

Just over fifty-three percent of male clients reported the use of this drug in 1990/91, compared with 36.1% of female clients. Males were also slightly more likely than females to use cocaine and hallucinogens

Figure 8.5 AFM Client Profile
Drug of Choice for Clients Consuming Drugs Other Than Alcohol: by Gender




Source: AFM Annual Statistical Review
(Multiple responses are possible.)

Female clients, on the other hand, are more likely to report the use of tranquillizers and narcotics and analgesics, than are males.

While 6.5% of male clients reported the use of tranquillizers during this reporting period, this drug was reportedly used by 15.6% of female clients.

Similarly, 3.9% of male clients reported the use of narcotics and analgesics in 1990/91, compared with 7.8% of their female counterparts.

## 8.3 OTHER CLIENT CHARACTERISTICS

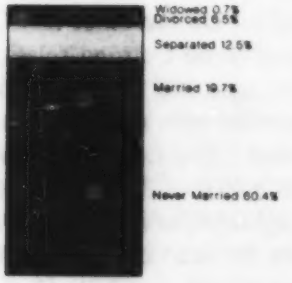
In describing the demographic profile of clients of the AFM who have reported the use of drugs other than alcohol, either in combination with alcohol, or on their own, it is important to note that client age is a key variable.

The disproportionate numbers of youth within this larger client population will, by definition, impact upon these findings. The reader is cautioned to keep this in mind when interpreting the significance of the following data.

**Marital Status:**

The majority of clients who reported using drugs other than alcohol had never been

Figure 8.6 AFM Client Profile
Marital Status of Clients Using Drugs Other Than Alcohol: 1990/91




(N=3,069)

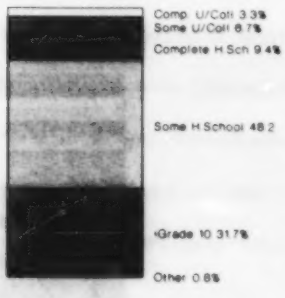
Source: AFM Annual Statistical Review

married (60.4%)(Figure 8.6). These are followed by clients who were married at the time of intake into AFM programs (19.7%); clients who reported being separated (12.5%); divorced clients (6.5%); and those who were widowed (0.7%). As with other characteristics of this population, the relative age of this population probably influenced these findings.

**Educational Attainment:**

The largest proportion of these clients had either some high school (48.2%); or grade ten or less education at the time they entered AFM programs (31.7%) (Figure 8.7). Of this latter group, 2.4% had completed between a grade four to six education, while 0.5% had less than a grade four education. Of the remaining 20.1% of these clients, 9.4% had completed high school; 6.7% had some university or community college education; and 3.3% had completed university or community college programs. Fewer than one percent reported "other" educational attainment.

Figure 8.7 AFM Client Profile
Educational Attainment of Clients Using Drugs Other Than Alcohol: 1990/91



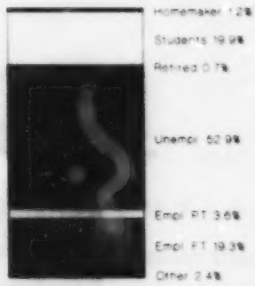

(N=3,069)

Source: AFM Annual Statistical Review

**Employment Activity:**

The largest proportion of clients who reported the use of drugs other than alcohol also reported being unemployed at the time when they entered programs of the AFM (Figure 8.8). This population accounts for 52.9% of clients who reportedly used drugs other than alcohol.

Figure 8.8 AFM Client Profile
Employment Status of Clients Using Drugs Other Than Alcohol: 1990/91




(N=3,069)

Source: AFM Annual Statistical Review

Clients who reported being employed on a full-time basis accounted for 19.3% of these clients, while 3.6% reported being employed on a part-time basis.

Although younger clients comprise a

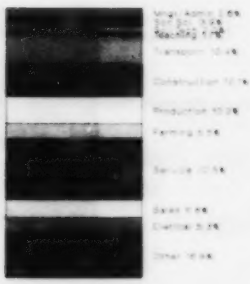
relatively large proportion of this population, only 19.9% reported being students at the time when they entered programs.

Of the remaining 4.3% of these clients, 1.2% reported that they were home-makers; 0.7% reported that they were retired; while 2.4% reported some "other employment activity.

**Client Occupation:**

Of the 693 clients for whom occupations are known, the largest proportion reported working in the service sector (22.5%) (Figure 8.9). This is followed by clients working in the construction trades

Figure 8.9 AFM Client Profile
Occupation of (Employed) Clients Using Drugs Other Than Alcohol: 1990/91



Source: AFM Annual Statistical Review

(12.1%); transportation and other equipment and materials handling trades (10.4%); production processing and related trades (10.2%); sales occupations (6.8%); farm and other resource occupations (5.5%); clerical and related occupations (5.3%); social sciences and artist occupations (3.9%); managerial and administrative occupations (2.6%); and scientific and technical occupations (2.0%). Other occupational categories are filled by the remaining 16.9% of these clients.

**Client Household Income:**

The largest proportion of AFM clients, who reported the use of drugs other than alcohol, also reported household incomes of under $10,000 (Figure 8.10). Adjusting the data to include only those clients who provided household income, 55.9% of these indicated that their total household income was under $10,000.

Figure 8.10 AFM Client Profile
Household Income of Clients Using Drugs Other Than Alcohol: 1990/91

Source: AFM Annual Statistical Review

Just over seventeen percent reported household incomes of between $10,000

and $20,000 annually; 10.5% reported household incomes of between $20,000 and $30,000 annually; 9.9% reported incomes of between $30,000 and $50,000 annually; and only 3.3% reported annual household incomes exceeding $50,000.

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